COUNSELOR COMMUNIQUE

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2004 Board of Directors

At the January 15, 2004, Board of Directors meeting, elections of officers were held. The 2004 Executive Officers are: John Gary, Southeastern Regional Representative - President; John Bowen, Member-at-Large Representative - Vice President; Stan Landon, Central Regional Representative - Secretary and Ron Cohen, Eastern Regional Representative - Treasurer.

It's Not To Late to Register!

Spring Training Institute 2004

The Missouri Department of Mental Health will present the Spring Training Institute from May 19-21, 2004 at Tan-Tar-A Resort and Conference Center at Osage Beach, Missouri. Hear from experts about a wide range of topics including:

- Trauma
- Homelessness and Housing Options
- Vocational Support
- Medication Management
- Relapse Prevention
- Motivational Interviewing
- Compulsive Gambling
- Methadone Maintenance Therapy
- Transition from Prison to Community Issues
- Anger Management
- Co-Occurring Disorders
- Cultural Competency

For more information view at:
http://www.dmh.missouri.gov/ada/documents/STI2004_000.pdf

Or phone 573-751-4942

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John Bowen, Vice President
Eastern Region

Stan Landon, Secretary
Central Region

Ron Cohen, Treasurer
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MSACCB Office Staff

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Danette Henderson
Board Assistant

Cheryl Mealy
Counselor Certification Spec.

2004 Calendar of Events

January 15	Board of Directors Meeting
February 4	Application Deadline for June Written Exams
March 18	Board of Directors Meeting
TBA	Continued Quality Insurance Committee
April 16-17	CPM Orals
May 13	Board of Directors Meeting
June 12	IC&RC Written Exams for CSAPP, CASAC & CSAC
July 15	Board of Directors Meeting
August 4	Application Deadline for June Written Exams
September 10-11	CPM Orals
September 16	Board of Directors Meeting
November 18	Board of Directors Meeting
December 11	IC&RC Written Exams for CSAPP, CASAC & CSAC

Missouri Substance Abuse Counselors' Certification Board, Inc.

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Web Page:

http://www.dmh.mo.gov/msaccb/

IC&RC Written and CPM Test Dates

CSAPP/CSAC/CASAC Exams

2004

Written Test: June 12,
(Application Deadline: Feb. 4, 2004

September 11,
(Application Deadline: May 4, 2004)

CPM:

April 16-17, 2004

August 6 -7, 2004

November 12-13, 2004

Clinical Supervision

This key to treatment success is gaining increased attention

By Gail D. Dixon, M.A., CAPP
NIDA Project Manager
Southern Coast ATTC

Intense competition for limited substance abuse program funds, combined with increased scrutiny of program costs and results, has created a need for better understanding of how clinicians, organizations and systems can work together to improve treatment outcomes. While clinical supervision has long been regarded as a significant part of the addiction treatment process, the importance of effective supervision has gained increased attention in this competitive environment. The emphasis on evidence-based practice has also contributed to renewed focus on the supervision process. This article will focus on the elements of effective clinical supervision in addiction treatment and explore the role of the clinical supervisor in an evidence-based practice environment.

Definition of Clinical Supervision

A variety of definitions for clinical supervision exist. Differences typically reflect aspects of the author's discipline and training focus. Bernard and Goodyear (1998) offer this definition that has come to be accepted within the counseling profession:

> Supervision is an intervention that is provided by a senior member of a profession to a junior member or members of that same profession. This relationship is evaluative, extends over time, and has the simultaneous purposes of enhancing the professional functioning of the junior member(s), monitoring the quality of professional services offered to the clients she, he, or they see(s), and serving as a gatekeeper of those who are to enter the particular profession.[1]

This definition identifies the participants in the relationship, the quality of the relationship and its purposes. The elements of this definition are present to varying degrees in all models of clinical supervision.

Models of Supervision

There are significant parallels between the supervision of staff and therapeutic work with clients. In both relationships, one participant takes on the responsibility of facilitating growth and change in the other participant through focused or structured interactions. There are some critical differences between counseling and supervision. Gallon (2002) has provided the following framework to make the comparison:[2]

Differences Between Counseling and Supervision

	Counseling	Clinical Supervision	Administrative Supervision
Purpose	Personal growth Behavior changes Decision-making Better self-understanding	Improved job performance	Assure compliance with agency policy and procedure
Outcome	Open-ended based on client needs	Enhanced proficiency in knowledge, skills and attitudes essential to effective job performance	Consistent use of approved formats, policies, and procedures
Time Frame	Self-paced; longer term	Short-term and ongoing	Short-term and ongoing
Agenda	Based on client needs	Based on service mission and design	Based on agency needs
Basic Process	Affective process which includes listening, exploring, teaching	Assessing worker performance, negotiating learning objectives, and teaching/ learning specific skills	Clarifying agency expectations, policy and procedures, assuring compliance

In general, models of clinical supervision have been classified by the philosophical framework that underlies the process. Clinical supervision models fall into these four basic categories: psychotherapy-based, developmental, social-role and eclectic. Developmental models of supervision have dominated supervision thinking and research since the 1980s. Developmental conceptions of supervision are rooted in developmental psychology — the description, explanation and modification of individual behavior across the life span. Such models are based on two basic assumptions:

In the process of moving toward competence, counselors move through a series of stages that are qualitatively different from one another
Each supervisee stage requires a qualitatively different supervision environment if optimal supervisee satisfaction and growth are to occur (Chagon and Russell, 1995).[3]

One of the most prominent writers on clinical supervision for the addiction treatment field is Dr. David Powell. Powell (1993) indicates that a model of supervision has a number of layers: Philosophical foundation — the theory of change that underlies the counseling approach to be used;
Descriptive dimensions — specific characteristics of the counseling and supervision processes;
Contextual factors — characteristics of client, counselor, supervisor and setting that affect the supervision environment; and
Stage of development — level of training, knowledge and skill of both supervisor and counselor.[4]

In Powell's view, the focus of supervision is behavioral change and skill acquisition. In other words, the emphasis should be on helping staff learn how to use personal skills and attributes in counseling to promote behavioral change in the client. Powell notes that models of supervision have tended to emphasize either skill development or the emotional/interpersonal dynamics and self-discovery of the worker. In chemical dependency, the emphasis has been on skill development. However, newer models have incorporated both. Stoltenberg and Delworth (1987) have developed an integrated developmental model for supervision that is used by Powell. In this model, the developmental levels of both counselor and supervisor are viewed with regard to: autonomy, self and other awareness and motivation.[5]

Critical Issues in Supervision
In most addiction treatment agencies, clinical and administrative supervision are performed by the same person. It is important to balance the time spent in supervision between these two elements. A supervisor is very often positioned as a bridge within the organization between upper management and front-line staff who are implementing organizational programs and policies. An inherent tension exists between the demands and expectations of these two organizational layers. The clinical supervisor must negotiate this balance in a way that facilitates both growth in the counselor and effectiveness in the organization. It is important to consider ethical principles that influence the practice of supervision. The same concerns for appropriate boundaries, maintaining confidentiality and unconditional positive regard that characterize the counseling relationship apply to the relationship between counselor and supervisor. The clinical supervisor must also make a commitment to his or her own growth and skill development within the changing context of the addiction field in order to provide the highest quality of supervision possible.

The clinical supervision process focuses primarily on building particular counselor skills or competencies.

Role of Clinical Supervision in Evidence-Based Practice
Clinical supervision has taken on increasing importance as the addiction field has moved toward evidence-based practice. Often, the clinical supervisor is the critical agent of change within the addiction treatment agency. As a change agent, the clinical supervisor must be familiar with the change process, adept at assessing readiness to change both within the agency and the counselor, and skilled at overcoming resistance. Another part of the supervision challenge is resistance. Another part of the supervision challenge is to be an advocate for the counselors (and by extension the clients) by promoting changes in the organization that can facilitate and enhance the work of the counselors. Counselors may have higher levels of satisfaction and be more productive if they feel organizational policies are working for and not against them. This challenge usually falls on the supervisor's shoulders. While managers and administrators often initiate the move toward evidence-based practice within a particular setting, supervisors and counselors are key to understanding which specific evidence-based interventions are timely and relevant for their clients' problems. That means they must provide leadership in the agency on the selection of evidence-based practices that address these needs.

One critical area of supervision in the evidence based environment is the focus on training. Counselors and supervisors often tend to seek training in small doses of novel treatment models rather than the more intensive dosage needed to fully master a specific evidence-based model. To provide leadership and promote staff development, supervisors must also be well trained in the evidence-based practice (and its conceptual model) that is being implemented and must be able to monitor adherence to that model. The clinical supervisor may be required to supplement initial training with both formal and informal follow-up learning opportunities. In addition, the clinical supervisor may be given the responsibility of monitoring adherence to the evidence-based model to assure fidelity in implementation. This task may be difficult for supervisors whose philosophy of supervision has been more exploratory or insight oriented, rather than skill-focused. Additional training in supervision for the specific evidence-based practice may be required.

The Southern Coast ATTC has identified training in clinical supervision as one of its strategic priorities. In the fall of 2003, we offered a series of three-day courses in clinical supervision in five cities throughout Florida. We are currently developing our training calendar for 2004 and will offer this course again. The ATTC is committed to developing the addiction workforce to respond to the demands of a changing practice environment. Equipping supervisors to fulfill their critical functions within the treatment framework is a key aspect of that development.

[1] Bernard, J.M. &Goodyear, B. (1998). Fundamentals of Clinical Supervision. (2nd ed.). Boston: Allyn & Bacon.

[2] Gallon, S. (2002) Clinical Supervision Training Manual. Portland, OR: Northwest Frontier ATTC.

[3] Chagon, J., & Russell, R. K. (1995). Assessment of supervisee developmental level and supervision environment across supervisor experience. Journal of Counseling and Development. 73, 553-558.

[4] Powell, D. (1993). Clinical Supervision in Alcohol and Drug Abuse Counseling: Principles, Models and Methods. New York: Lexington Books.

[5] Stoltenberg, C.D. and Delworth, U. (1987). Supervising Counselors and Therapists. San Francisco: Jossey-Bass.

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James Douglas Saul
Sadie Shipman
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Dele J. Williams
Rebecca Woody
Jana A. Zajac

CSAC II by Reciprocity

Jacqueline S. Welborn

CASAC by Reciprocity

Henry Joseph Bohon

Expired Certified Counselors October 31, 2003

Paul Anderson	CASAC	
Thomas Bock	CSAC II	R
Any Brinkman-Viall	CASAC	R
Ann Brooks	CASAC	
Clarence Chambers	CSAC II	
Kay Creason	CASAC	D
Raymond Cruthis	CSAC II	
Channie Davis	CSAC II	
Olga Delavara-Solomon	CSAC II	
Richard Dolan	CSAC I	
David Duncan	CSAC I	
Margaret Felling	CSAC II	E
Terri Frank	CSAC II	
Dennis Gallichant	CSAC II	R
Charles Gill	CSAC II	E
Stacy Gillilan	CSAC II	
Joyce Goudeau	CSAC II	
Milton Gray	CSAC I	
Darline Grebe	CSAC II	
Paula Hartley	CSAC II	R
Edward Hester	CASAC	E
Dennis Howard	CASAC	
Tina Hunt	CSAC II	R
Timothy Lawler	CSAC II	
Eric Leslie	CASAC	
Lillie Marabel Douglas	CSAC II	
Michael McCloskey	CSAC II	
Anita McCormick	CSAC I	
Nancy McReynolds	CASAC	
Rebecca Mercurio	CSAC II	
Dennis Phelan	CSAC II	
Donald Pittman	CSAC II	
Raymond Radtke	CSAC II	
Judith Richards	CASAC	R
Judith Riehl	CSAC I	
James Rogers	CSAC I	
Mary Shepard	CSAC II	E
John Snyder	CSAC II	
Nathan Taylor	CSAC II	E
Angela Thomas	CSAC II	
Jeffry Till	CASAC	
Cathy Ward	CSAC II	
Robert Warren	CSAC II	
Michael Welton	CASAC	D
Peggy Wilfong	CASAC	
Leeotia Williams	CSAC II	E

D Deceased
R Reciprocity
E Emeritus Status

Expired RASAC II's October 31, 2003

Danny Adams	RASAC II
Melinda Allen	RASAC II
Genie Amen	RASAC II
Rebecca Benoist	RASAC II
Bruce Burgo	RASAC II
Linda Cooper	RASAC II
Beth Drewett	RASAC II
Judith Frakes	RASAC II
Jessica Gardner-McGill	RASAC II
Brenda Garner	RASAC II
Carolyn Hampleman	RASAC II
Diana Hatfield	RASAC II
Geraldine Johnson	RASAC II
Craig Lancaster	RASAC II
Jack Manion	RASAC II
Harriet Rice	RASAC II
Noble Shaver	RASAC II
Paul Simmons	RASAC II
Teresa Smith	RASAC II
Terri Strait	RASAC II
Jackie Truett	RASAC II
Laura Tubbs	RASAC II
Amy Vescovo	RASAC II

Application Deficiencies that Delay Applications Being Sent to the Credentials Committee for Final Review

Applicant Deficiencies

- State of Missouri Caregiver Background Screening Form is not completed and mailed along with the $5 processing fee to the Missouri State Highway Patrol immediately upon receiving their application packet
- Do not list detail of duties on page 3 for current and past positions
- Do not attach a job description for current position
- Forget to sign and date page two of the Counselor Development Plan
- Forget to sign the code of ethics and authorization and release on page 6 of the application
- Sending student issue transcripts with their application materials
- Do not have official transcripts sent directly from the college/university to the MSACCB
- Do not list the educational trainings they have completed on pages 4 and 5 of the application.
- Do not send the training certificates or letters of completion for the trainings they listed on pages 4 and 5 of the application.
- Do not send the original and 3 copies of their case study to be used for the CPM
- Failing to check with MSACCB staff regarding the status of their application before it expires at the end of the 90 days allowed to correct application deficiencies.
- Move and do not advise the MSACCB of their forwarding address.

Supervisor/Employer Deficiencies

- Do not attach job description(s) for all the positions listed on the Counselor Employment Verification Form.
- Do not document the percentage of time working in the 12 core functions on the Counselor Employment Verification Form.
- The totals for the performing or supervision hours documented in the 12 core functions on the Supervised Practicum Experience Form do not agree with the totals documented at the bottom of the page.
- Forget to sign and date page two of the Counselor Development Plan
- Forget to sign the cover page of the applicants case study to be used for the CPM
- Does not document the <u>future dates</u> of the plan on page one of the Counselor Development Plan

Other Deficiencies

- One or more of the three letters of recommendation are not sent to the MSACCB

If you or your supervisor have any questions regarding initial application or upgrading, please call us so that we may answer your questions.

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